Treatment of Mental Illness

The Use and Misuse of Sedation and the Seclusion Room

HARRY A. WILMER, *M.D.*, Bethesda, Maryland

• **Nine hundred and thirty-nine patients admitted to the locked receiving ward in the psychiatric service of the U. S. Naval Hospital, Oakland, over a ten-month period, many of them psychotic and in an acute initial episode, were treated with an intensive group therapy program, which more appropriately should be called a therapeutic community. During this time, the ward medical officer did not put any patients in a seclusion room. Patients who did not require a locked ward were quickly transferred to the open receiving ward which was established five months after this program began.**

It was possible to greatly diminish the quantity of sleeping medicine prescribed and practically to eliminate the use of barbiturates given parenterally. Restraints were never used. To be dealt with in this atmosphere of candor and relative freedom seemed to evoke a responsive attitude in the patients and many of them benefited from it.

THE PURPOSE of this communication is to report an experiment in the operation of the receiving ward of the psychiatric service at the U. S. Naval Hospital, Oakland, California, over a ten-month period. During that time, it was found that barbiturate sedation was in most instances unnecessary, and often contraindicated, and that use of the seclusion room was not required. No form of mechanical restraint was employed. Cold packs were not used and there was no hydrotherapy available on the ward. It is felt that the experience on this ward, dealing with a total of approximately 1,000 patients, has direct bearing upon the care of emotionally ill and mentally ill patients in offices and in general and psychiatric hospitals.

Between July 1955 and mid-April 1956, the author was medical officer on the admission ward. In that time 939 patients were received on this ward, where they remained for an average of ten days before being assigned to a locked or unlocked ward in the psychiatric service. In addition to routine admission procedures and responsibilities, this ward was organized as a "therapeutic community." (This concept was adapted, with modifications, from the techniques and philosophies of Dr. Maxwell Jones, Belmont Hospital[4]; Dr. T. P. Rees, Warlingham Park[7]; and Dr. T. F. Main, Cassel Hospital,[6] which the author observed while on temporary naval duty in England.)

The ward was a large temporary wooden structure containing 34 beds lined up on either side of a single room. The outside doors were locked and patients were not permitted off the ward unattended. There were two nurses on duty during the day, three or four corpsmen, and a social worker. The staff was not selected but was designated in normal rotation of Navy personnel.

The concept of the therapeutic community involves as free communication as possible between patients, between patients and staff and between members of the staff. Treatment is continuous through 24 hours of each day on the ward, and whatever is said or done there is a matter of ward concern. Above all the therapeutic community is based on a sincere concern for the welfare of the patients. Without this, no amount of technique will work. In the present experiment the staff was told in the beginning that the use of the quiet room would be discontinued and that sleeping pills were to be given only in unusual circumstances. A formal sick call was to be held at 8:30 each morning, followed by a ward group meeting lasting about 45 minutes, at which all patients and staff—nurses and corpsmen—were expected to be present. Only the simple device of firmly expecting the patients to attend was used—no threats or demands—and only two of 939 patients refused to attend meetings. Both were severe paranoid schizophrenic patients overwhelmed by fear.

Immediately after the group meeting, the staff met separately for 30 minutes, during which time the meeting was discussed and ward or staff problems were brought up. The night crew would leave a letter about the previous evening's activity on the ward, and the ward medical officers would write them about the day's happenings. These written communications were usually read to the staff. While the staff was holding its separate meeting, the patients gathered in a spontaneous group on the ward. Once a week a

Commander, Medical Corps, U. S. Naval Reserve, U. S. Naval Hospital, Oakland; now assigned to Naval Medical Research Institute, Bethesda, Md.

Presented before the Section on Psychiatry and Neurology at the 85th Annual Session of the California Medical Association, Los Angeles, April 29 to May 2, 1956.

Assistant Clinical Professor of Psychiatry, Stanford University, San Francisco (on military leave).

The opinions contained herein are those of the author and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

meeting was held with the corpsmen, and another with the nurses. In effect, this was on-the-job training for personnel.

At first, the staff doubted whether the ward could be operated in this fashion, without use of quiet rooms, restraint and parenteral sedation. Within two or three months the fact that it *would* work was obvious to all; but even more striking was that the best and most humane qualities in staff and patients were brought to the fore. It was, as one corpsman said, "believing in what you are doing—I suppose one could say faith."

The routines of the ward were simple, yet in a sense demanding. It was group-oriented—yet group therapy *per se* played only a small part. It was group living and intergroup living; it was continuous communication and the process of enculturation into the hospital.

When a patient entered during working hours, he was seen by the ward physician within an hour. Strict adherence to this simple rule had a decided effect on many patients. The friendly meeting, with a brief explanation of how the ward was conducted, was motivated by a sincere interest in the patients—a fact which most of them wanted to believe but of which a few were suspicious. It was capitalizing on the reservoir of faith that most people have in physicians. On the bulletin board in the ward was placed a sheet of paper on which any patient wishing to speak with the doctor individually could write his name. Each was seen in order, as time permitted, but always within 48 hours. The names were conspicuously checked off for all to see. This had the effect of decreasing demands for interview, and a glance at the list would serve as a barometer of ward pressure.

Since, so far as could be determined, there is no published experience of daily group work on an admission ward in a military hospital that could be used as a guide, our concepts were developed and adapted as time went on. Because of the rapid turnover of patients, it was found advantageous to add a Saturday group meeting. The group served as a constant safety-valve and was often a moving manifestation of the wish of people to help one another.

Being the only medical officer served me to advantage, since thus I knew each patient individually. The nurses, corpsmen, patients and I all belonged to the same military organization, and every effort was made to utilize the best features of military life for therapeutic goals. For example, certain ideas of obedience and conformity, respect and pride of belonging to a group unit, the spirit of working together for survival, the tolerance of racial and religious differences and self-respect were utilized to foster a favorable treatment situation. Twice a week I met briefly in my office with the patients who were officers, chief petty officers and sergeants, and as a consequence they were able to retain their self-respect and status to some degree.

The special nature of the patient sample should be given careful consideration in evaluating the results. Data on the first 250 patients were analyzed as follows: Navy personnel comprised 75 per cent of the group, and Marine Corps personnel 24 per cent. The average age was 24.3 years, and the average length of service was 4.7 years. Of the 250 patients, 91.1 per cent were Caucasian, and two-thirds of the remaining 8.9 per cent were negroid. The group included nine officers and 29 sergeants or chiefs. Admission records showed that 21.6 per cent of the patients had come to the hospital from foreign stations, 32.4 per cent from ships in the Pacific and 46 per cent from shore stations in the United States. In terms of diagnosis, 44.4 per cent of the patients were psychotic (principally with mixed schizophrenic reactions or paranoid schizophrenia); 35.6 per cent were psychoneurotic; and 20 per cent had character or personality disorders. Almost all the psychotic patients had had no previous episodes of acute manifestation of disease and had had no previous treatment except in transit.

This communication will not discuss the group meetings in detail. It should be borne in mind, however, that group membership was constantly changing, with an average of three patients coming and going every day, and that the entry of severely sick new patients formed a spontaneous psychodrama.

In the year preceding July 1955, judging by a careful study of the psychiatric service log, there had been numerous incidents and disturbances. During the three months I had observed this ward as occasional officer of the day, I noted that the two quiet rooms were in almost constant use, and often patients could be heard beating on the doors. In these small bare locked rooms with only a mattress on the floor and the words QUIET ROOM painted over the door, patients who were most psychotic, delusional and hallucinatory were placed immediately on admission, *as if* they were too sick to be on the ward. Patients who had attempted suicide or were thought to be seriously suicidal were placed in these rooms *as if* it were not safe for them to be on the ward. It was a common procedure to give the disturbed patients barbiturates intravenously on admittance, which often made confinement in the seclusion rooms seemingly mandatory, since the patients became more confused, more disturbed by their sense of unreality and hallucinations and less responsive to directions. Moreover they were rendered weak and powerless and lost coordination.

It was our belief that the seclusion rooms did not offer as great safekeeping as the open ward, that use of them fostered regression and withdrawal, accentuated the fear of social contact, increased the sense of stigmatization as insane, confirmed the fear in a patient that he might lose all control and go to pieces, tended to lower self-control by placing him in a situation where he "could go crazy," or fostered in some neurotics the need for special privilege. For those patients who were not in the seclusion room, it meant other things: Some were intimidated, fearing they might be next; some of the sicker ones misinterpreted the yelling they heard from the seclusion rooms. For example, one psychotic patient, describing an experience in a previous hospital, demanded of me in the first interview, "What did they do with the body?" It turned out that a patient had been placed in a quiet room and then had been transferred to another hospital without making a reappearance on the ward. In other patients fears were aroused about the patients who were thought so dangerous by the doctors that they had to be in solitary confinement. Furthermore, if a doctor acquiesced in sending a patient to the quiet room on his own request, he often became a partner in the patient's acting out.

In July 1955, instructions were given to the staff that we would operate the ward as if we did not have quiet rooms. Within a month the mattresses were removed from the quiet rooms; one of the rooms was then furnished as an office and the other as a music room, with a piano. I was always aware of the possibility that an emergency could arise requiring isolation, but felt that even if that did occur, it would only be the exception to the rule.

Over a ten-month period with about 1,000 patients, a few of them desperately psychotic, suicidal or homicidal, I did not once find it necessary to place a patient in a seclusion room. It was not uncommon for as many as five to ten patients at a time to be admitted to the ward—some of them in various forms of mechanical restraint and many of them having spent days or weeks in seclusion rooms in other hospitals. Despite the fact that we told the patients we did not use quiet rooms on this ward, on five occasions the officer of the day, who was not a member of the admission ward staff but a psychiatrist from a different ward, placed a patient in a quiet room at night. The first time was six weeks after the ward began to be operated as a therapeutic community, and it came to my attention in a curious way. On a Wednesday morning, after a group had talked considerably about insomnia, a patient had become angry because of being refused a sleeping pill by the corpsman. This patient asked to see me after the meeting, and he told me he had been unable to sleep since a nightmare he had had early the previous Monday morning. "Someone was yelling and getting hurt," he said. "I tried to wake up but couldn't. I felt paralyzed. Finally I awoke, afraid. I looked at my watch and it was 3 o'clock. I fell asleep in about an hour."

I mentioned this patient's dream to the nurse that afternoon and she told me that early on Monday morning the patient in the bed next to his had become upset, said he was afraid he would lose control and hurt someone, and asked to be placed in the quiet room. The officer of the day had come to see him at 3 a.m., prescribed a sedative and placed him in the quiet room, where he remained for an hour.

Upon learning this, I reviewed my notes on the group meetings, and found that Monday's group discussion, which had been devoted to the problem of being a mental patient, had been punctuated by statements by patients such as "God helps those who help themselves." In summarizing the group discussion of that day, I had noted that the patients spoke as if they had been talking about the need to deny certain things and that while they had talked a great deal, there seemed to be an idea that talking was dangerous.

As time went on this interpretation was confirmed, for it was observed that patients tended to have the feeling, when they first came into the hospital, that if they talked about what was *really* on their minds, they would be put in the quiet room.

I talked to the patient who had been angry because he was unable to sleep, and he denied any knowledge that the patient next to him had been anywhere except in his bed throughout the night. However, the insomnia disappeared.

In the second incident involving use of the quiet room, the patient had been admitted on the week-end —these quiet room incidents occurred on week-ends —and I had not seen him. He was a manic depressive patient in a manic phase and had been in a seclusion room in another hospital. He had been reassured by a corpsman that quiet rooms were not used on this ward. Later in the night, however, the officer of the day had been called to see the patient, had given him a large dose of a barbiturate and had put him in the quiet room. The Monday morning group discussion began with great excitement, with the patient in question standing up and yelling at me, "Speak, doctor, speak. I'm not afraid of being crazy, I'm not going to hurt you." When I asked him directly if he had been in a quiet room, he became even angrier with me, suspecting subterfuge, which was in keeping with experience on the ward—that is, reality. It was not necessary to seclude this patient again, and he made a reasonably good recovery, although on one occasion he provoked a brief fight.

In an individual interview with the patient after the group meeting, he cried almost the entire time. I asked him about the night before, and he replied: "How did I feel? How do you think I felt? I'm not supposed to be put in a quiet room by anyone just because he hates me. You know and I know that I'm sane. I won't hurt you. The officer of the day thought I was crazy. He didn't like me. I don't want to go back in the quiet room. You won't put me there, will you?" He then related to me a profound claustrophobia from early life.

The next instance of a patient being put in the quiet room on the admission ward was again not directly brought to my attention. The officer of the day transferred a patient who was drunk from open ward to admission ward, placing him in a quiet room with instructions that he was to be returned to the open ward at 7 o'clock the next morning.

The fourth patient placed in the quiet room was a hebephrenic schizophrenic patient who requested immediately on admission that he be given a private room. This was on a Sunday and on Monday morning he was removed from the quiet room.

It was five months before another patient was placed in the quiet room. This time a patient who, before admittance, had tried to kill himself by cutting his wrists, was heavily sedated with sodium amytal by the officer of the day. Then, because he was so groggy he could not stand, he was placed on a mattress in the quiet room. He might have been placed in a bed on the ward equipped with side rails.

It should be emphasized that over half of the patients admitted to our ward were not psychotic. It was for aggressive patients, or for the occasional patient who was greatly disoriented, delusional or tormented by hallucinations, that seclusion had been considered in the past. Now, on almost any day the ward would look like any medical or surgical ward, the patients conversing quietly, friendly and well behaved.

Unquestionably the seclusion room is sometimes used punitively; witness the colloquialism, "Throw 'em in the quiet room." Unquestionably also, patients are sometimes maltreated, and this maltreatment usually takes place in a quiet room or in an isolated room where it cannot be witnessed. This is one of the reasons putting an end to such practices is difficult—and also one of the reasons why care of the mentally ill must be brought into the open, both literally and figuratively. The physician himself must be responsible for seeing that maltreatment of the mentally ill does not occur even occasionally.

There is nothing new in the approach discussed here. With regard to sedation, there are innumerable references in the literature to its abuse. As to restraint and seclusion, over one hundred years ago it was argued before the American Psychiatric Association that nonrestraint might work for the relatively mild, complacent English but not for the more violent, liberty-loving Americans.

Only about 8 per cent of the first 250 patients admitted in the period reviewed received the tranquilizing drugs chlorpromazine and reserpine. After four months, when it became evident that the social and therapeutic experience of the ward milieu was effective and that its efficacy did not depend upon medication, we felt free to evaluate the newer drugs on this ward. Consequently, by the end of ten months 27.6 per cent of the patients were receiving one or the other of these drugs. They were considered to be of particular help in the more aggressive, hyperactive psychotic patients and patients in delirium tremens.

Table 1 shows the use of barbiturates on the receiving ward during the period of the therapeutic community in comparison with their use during the four months immediately preceding its establishment. In the preceding four months, during which 440 patients were admitted, 263 doses of barbiturates and 51 injections of sodium amytal had been given. In contrast, during the first full four months of the therapeutic community experiment, a period in which 367 patients were admitted, 53 doses of barbiturates and five injections of sodium amytal were given; and in the last four-month period of the experiment, with 443 patients admitted, there were only 19 doses of barbiturates given and five injections of sodium amytal. During the entire ten-month period under review, the ward medical officer ordered only 23 doses of barbiturates and three injections of sodium amytal, for patients in acute excitement; all the remaining were given on order of the officer of the day.

The decline in the use of the quiet room and sedation on the receiving ward, as well as an increase in use of the tranquilizing drugs, coincided with a decrease in use of electroshock and a discontinuance of the use of insulin coma therapy in the hospital. Only one patient received electroshock while in the admission ward. He was very violent on admission, kicking in a door and striking at me, but he settled down and remained quiet on the ward, although he would not come to the group meetings. On one occasion, he took a corpsman's key and ran from the ward. At no time did he strike another patient or do any violence once he was in pajamas and actually admitted to the ward. I was so inseparably enmeshed in his delusional system that he was almost totally out of reach of psychotherapy. He improved dramatically after a number of electroshock treatments. In general, however, it was my impression

TABLE 1.—*Use of Barbiturates on the Receiving Ward Between January 1955 and April 1956

	No. of Admissions	Nembutal 100 mg.	Seconal 100 mg.	Sodium Amytal 0.2 gm.	Sodium Amytal Intramuscularly 0.5 gm.
1955 (prior to therapeutic community):					
Mar.	128	23	18	21	19
Apr.	116	40	6	10	19
May	99	18	27	12	10
June	97	52	31	5	3
	440	133	82	48	51
(Transition month):					
July	79	43	10	5	1
(Therapeutic community):					
Aug.	91	7	9	0	1
Sept.	90	5	16	6	0
Oct.	86	5	1	0	0
Nov.	100	0	2	2	4
	367	17	28	8	5
Dec.	102	0	1	0	0
1956:					
Jan.	127	0	5	5	2
Feb.	86	0	4	0	1
Mar.	128	0	4	0	2
	443	0	14	5	5

*These data are taken from the nursing log. In addition to the above, one injection of sodium phenobarbital was given in March, 1955, and one in March, 1956. Phenobarbital 30 mg. was given largely in cases of epilepsy after July, 1955, a total of 145 tablets in all. In the preceding four months, 58 tablets were given. A total of 1 cc. of nembutal was given after July, 1955, and no sodium amytal. The total of 939 includes 50 patients admitted in early April 1956.

that the pendulum swung too far—that electroshock was not given to depressed patients who might well have profited by it. This is understandable, perhaps, in light of the history of abuse of electroshock in the last decade. But abuse of the prescription of sleeping medication can, I believe, run no danger if the pendulum swings far the other way. If one is going to decrease the amount of barbiturates, it is necessary to discuss the matter with the patient, and also to talk with him about the reason for his insomnia. Patients who have been taking barbiturates every night for a month have had medication discontinued, to their conscious relief, and have found that after a few restless nights they have usually worried their problems through to relatively constructive solutions. This is not necessarily done alone, but is facilitated by the therapeutic community.

It was our definite impression that giving barbiturates by mouth or by injection in large doses made schizophrenic patients more confused, more at the mercy of hallucinations and delusions and at a great disadvantage in dealing with reality. It fostered disorientation and clouding of consciousness and perception. It also seemed to make schizophrenic patients less amenable to psychotherapy. The routine use of barbiturates in the transfer of patients from hospital to hospital was observed as a definite complication in the transportation and reception of the patient. The routine use of barbiturates for neurotic patients and patients with character disorders who were being transferred was not only resented by them but was found to be unnecessary and even deleterious.

Many physicians apparently feel that in dealing with an acutely disturbed patient the first thing to do is to put him to sleep. There is also an impulse toward ordering sleeping medicine for insomnia patients. Many times, it seems from reading the records, these drugs have been given not because the patient could not tolerate his anxiety and insomnia (as evidenced by his toleration of it on our ward) but because the physician could not tolerate the anxiety aroused within himself. Another reason for the "routine" prescription of sleeping medicine is to insure the physician's own sleep. The care of the patient begins always with *caring* for the patient.

A patient came to my office one evening for a sleeping pill, saying he had been given one every night in another hospital since he had been sick. I explained that this was not done on this ward except in unusual circumstances and that patients tended to become dependent on these drugs. He said he thought that was a good idea and thanked me. He slept that night. The next day, he asked to see me and said, "I left your office reasoning a lot of things out, and was much more relaxed. I reasoned them out for myself for the first time. I realized I hadn't lost my faith or my family. I called my father. He reassured me that everything would be all right. I suddenly felt relaxed and dropped off to sleep. I dreamed about my wife."

The problem of the sleeping pill is not unlike the problem of the quiet room. We are asking people to call upon the reservoir of strength existing within them. Just as the sleeping pill diminishes stress to a point where a patient is often at the mercy of his fantasy and distorted thinking, so the seclusion room, with its absence of social stresses, produces other stresses of its own. There is evidence in the literature that isolation *per se*, even in healthy persons, acts as a powerful stress; and when the level of physical stimuli is diminished to the lowest possible point, a normal person may be driven to visual hallucination.[5] It is my clinical impression that isolation in the seclusion room and the use of restraints and barbiturates in large doses act as stress factors stimulating further psychotic symptoms and aggressive behavior.

There is a great deal written in the literature about meeting the patient's needs. One of the needs is to set limits. The therapeutic community has permitted us effectively to set limits on social behavior, making the seclusion room practically unnecessary,

and has permitted us to set limits on the prescription of sedatives—in effect, to say no. A very hostile Marine officer, aware of our policy in regard to sleeping medication, demanded in the middle of the night that the corpsman call the officer of the day for a sedative. The patient stood by as the corpsman called the doctor, who instructed the corpsman to give the patient what he requested. The patient, without waiting to hear the answer, turned away in sullen resignation (and probably some satisfaction of a hostile nature) saying, "Yeah, I know—no pills," and walked to his bed and fell asleep.

Naval Medical Research Institute, Bethesda 14, Maryland.

ACKNOWLEDGMENT

The author wishes to express his appreciation to Rear Admiral Bartholomew Hogan, Surgeon General, U. S. Navy; Capt. George Raines, Chief of Neuropsychiatry Branch, U. S. Navy, and particularly to the staff of U. S. Naval Hospital, Oakland, for their help.

REFERENCES

1. Bexton, W. H., Heron, W., and Scott, T. H.: Effects of decreased variation in sensory environment, Canad. J. Psychol., 8:70-76, 1954.

2. Bridger, H.: The Northfield experiment, Bull. Menninger Clinic, 10:71-76, 1946.

3. Deutsch, A.: The Mentally Ill in America, Columbia Univer. Press, p. 216, New York, 1949.

4. Jones, M.: Social Psychiatry, a Study of Therapeutic Communities, Tavistock Publications, Ltd., 1952.

5. Lilly, J. C.: Effects of physical restraint and of reduction of ordinary levels of physical stimuli on intact healthy persons, presented at the meeting Group for Advancement of Psychiatry, Nov. 13, 1955, in press, G.A.P. Reports.

6. Main, T. F.: The hospital as a therapeutic institution, Bull. Menninger Clinic, 10:66-70, 1946.

7. Rees, T. P.: Personal communication.

8. Skellern, E.: Therapeutic community, Nurs. Times, April-June 1955.

9. Wilmer, H. A.: A hitherto undescribed island: An approach to the problem of acculturation, American Scientist, 41:456, 1953.

10. Wilmer, H. A.: A psychiatric service as a therapeutic community, U. S. Armed Forces Med. J., 7:640-654, May 1956; 7:1465-1469, Oct. 1956.